

SD BOARD of EXAMINERS for COUNSELORS and MARRIAGE & FAMILY THERAPISTS
APPLICATION FOR LICENSED PROFESSIONAL COUNSELOR-MENTAL HEALTH
(ARSD 20:73)

NOTE: Applicant must be a Licensed Professional Counselor with two years post-graduate clinical experience in mental health counseling acceptable to the board (see Section III) to be eligible for LPC-Mental Health.

Applications must be accompanied by a non-refundable license application fee of \$100. A personal check or money order should be made payable to the South Dakota Board of Examiners for Counselors and MFTs. *I hereby make application for licensure to practice as a Licensed Professional Counselor-Mental Health in the State of South Dakota.* (Please type or print legibly the following.)

SECTION I. GENERAL INFORMATION

1. Name _____
Last First MI
2. Name as you wish it to appear on the license _____
3. Social Security No. _____ Date of Birth _____
4. Home Address _____

5. Business Address _____

6. Home Phone # _____ Business Phone # _____
7. Do you hold a current LPC license in South Dakota? NUMBER _____ If no, SDCL 36-32-42(1) requires that you obtain licensure as a licensed professional counselor.
8. I have / have not (CIRCLE ONE) made a previous application to South Dakota Board of Examiners for Counselors and MFTs. If yes, please state on a separate sheet of paper.
9. I have / have not (CIRCLE ONE) ever been convicted of, pled guilty to, or pled no contest to, an offense that could have resulted in incarceration for more than a year. If yes, please explain on a separate sheet of paper.
10. I have / have not (CIRCLE ONE) had a license denied, revoked, suspended, or otherwise acted against for any reason in another state, territory, or in South Dakota. If yes, please explain on a separate sheet of paper.
11. I have / have not (CIRCLE ONE) been disciplined by a mental health licensing or certification board or by any mental health related professional organization. If yes, please explain on a separate sheet of paper.
12. I am / am not (CIRCLE ONE) \$1,000 or more behind in child support payments.

SECTION II. GRADUATE COUNSELING PROGRAM (ARSD 20:73:03)

13. List the institution(s) from which you have received graduate degrees in counseling. **A transcript of your graduate degree must be sent directly to the Board's office by the institution awarding the degree.** Also, complete Attachment B and submit it to the Board.

UNIVERSITY/COLLEGE _____
CITY/STATE _____
DEGREE & DATE GRANTED _____

SECTION III. SUPERVISED EXPERIENCE (ARSD 20:73:04)

The applicant must have 2,000 hours of post-graduate direct client contact in a clinical setting experienced in no less than two years, which includes one-hundred hours of direct supervision [at least fifty hours of which shall be face-to-face supervision, the balance may be face-to-face or by secure telephone conferencing or interactive video conferencing]. One hour of supervision, under a licensed mental health professional acceptable to the Board, must take place each week. **Complete Attachment A, and forward it to the supervisor(s) who supervised you.** The supervisor(s) should return the form to the Board.

SECTION V. EXAMINATION (ARSD 20:73:05)

The NBCC Clinical Mental Health Counselor Examination (NCMHCE) is required for this license. If you have taken the NBCC Clinical Mental Health Counselor Examination (NCMHCE), **you must request the testing center to submit a certified copy of your test score directly to the Board** before your application can be processed.

TYPE OF EXAMINATION - NCMHCE

DATE TAKEN _____

If you have not taken the National Clinical Mental Health Counselor Examination, you must contact the National Board for Certified Counselors at www.nbcc.org/stateboardlist?state=SD for the appropriate Handbook and registration page.

SECTION VI. AFFIDAVIT

I hereby state that I have fully read and understand the questions presented in this application and have answered them truthfully and completely. I acknowledge that my failure to make a full and accurate disclosure of any information called for herein may result in the denial of my application. I further acknowledge that any license or certification I may obtain on the basis of this application may be revoked or suspended for my failure to disclose full and accurate information herein.

I will furnish additional information or documentation as may be deemed necessary by the South Dakota Board of Examiners for Counselors and MFTs for their verification of the information I have disclosed in this application.

I will not hold myself out as a state Licensed Professional Counselor-Mental Health until the license authorizing me to do so is in my possession.

I hereby declare under penalty of perjury that the foregoing answers and statements are true and correct.

STATE OF _____)
:SS

COUNTY OF _____)

The undersigned, being duly sworn deposes and says that he/she is the person who executed this application; that the statements herein contained are true in every aspect; that he/she will conform to the ethical standards of conduct in his/her profession; and that he/she has read and understands this affidavit.

Dated this ____ day of _____, 20____.

Signature of Applicant

Sworn to before me this _____ day of _____, 20____.

NOTARY PUBLIC

My Commission expires:
(SEAL)

SD Board of Examiners for Counselors and Marriage & Family Therapists PO Box 2164 Sioux Falls, SD 57101-2164
(605/331-2927)

ATTACHMENT A -- SUPERVISED EXPERIENCE (ARSD 20:73:04)
LICENSED PROFESSIONAL COUNSELOR-MENTAL HEALTH

APPLICANT'S NAME: _____
Last First MI

The individual listed above is applying for a license to practice counseling in the State of South Dakota. The South Dakota Board of Examiners for Counselors and MFTs (Licensing Board) requires submission of information by the supervisor(s), which will enable the Board to evaluate the extent and quality of the candidate's supervised experience.

To be completed by Applicant (Please type or legibly print):

1. Name of Supervisor: _____
2. Address of Supervisor: _____

3. Name and nature of setting in which supervised practice took place: _____

- | | | |
|---|--|-------|
| 4. Dates of supervision by <u>this</u> supervisor at <u>this</u> setting: | START (mm/dd/yy) | _____ |
| | END (mm/dd/yy) | _____ |
| 5. Total number of DIRECT CLIENT CONTACT hours during period listed above: | | _____ |
| 6. SUPERVISORY HOURS: | Total Number Face-Face | _____ |
| | Total Number of Group or by Secured Conferencing | _____ |
| “I attest to the fact these hours are true and accurate.” Supervisor’s Initials _____ | | |

7. Please describe the nature of the applicant’s duties: _____

8. Please describe the nature of the supervision provided: _____

(over for Supervisor portion)

ATTACHMENT A -- SUPERVISED EXPERIENCE
(ARSD 20:73:04)
LICENSED PROFESSIONAL COUNSELOR-MENTAL HEALTH

-Continued-

To be completed by Supervisor (Please type or print legibly in ink):

9. I have reviewed the applicant's statements. They are _____ / are not _____ substantially correct.
(Please add any corrections on a separate sheet of paper.)
10. The quality of the applicant's performance during the supervision was: (check one)
_____ Outstanding _____ Good _____ Fair _____ Poor
11. Per Administrative Rule **20:73:04:02 Supervisor requirements and duties: Supervision shall include at a minimum two of the four following methods ...**
What were the two or more methods you used to comply with the supervision rule: _____

12. My type of professional counseling license during this supervision*: _____
License Issue Date*: _____
{*Must have been licensed in accordance with ARSD 20:73:04:02 prior to the start of supervision.}
License Number: _____ State of: _____

I attest to the fact the information I have provided above is true and accurate and that I was solely responsible for this applicant's supervision as documented on side one of this Attachment A.

Supervisor Signature

**Mail completed form to: SD Board of Examiners for Counselors and Marriage & Family Therapists, PO Box 2164,
Sioux Falls, SD 57101-2164
(605) 331-2927**

ATTACHMENT B
LICENSED PROFESSIONAL COUNSELOR-MENTAL HEALTH (ARSD 20:73:03)

- A 60-hour Master's degree in Counseling approved by the Council for Accreditation of Counseling and Related Educational Programs (**CACREP**) as listed in "Directory of Accredited Programs," July, 1994; **OR**
- An equivalent Masters degree in Mental Health Counseling or related program which includes coursework in the content areas below.

Academic requirements must be completed at a university or college accredited by one of the following. Check your school's accreditation body:

- _____ (1) The Middle States Association of Colleges and Secondary Schools;
- _____ (2) The New England State Association of Colleges and Secondary Schools;
- _____ (3) The North Central Association of Colleges and Secondary Schools;
- _____ (4) The Northwest Association of Colleges and Secondary Schools;
- _____ (5) The Southern Association of Colleges and Secondary Schools; or
- _____ (6) The Western College Association.

In the blanks provided, please write which course number(s) meet(s) these requirements from your transcript. If a course title is not clearly indicative of the content areas as outlined below, include the college catalog description or course syllabus and highlight the areas of the literature that best demonstrate coverage of the content area.

Content Area	Course Number(s)	Course Title(s)	College/ University
Counseling theory: including a study of basic theories and principles of counseling and philosophic bases of the helping relationship;			
Counseling techniques: including individual counseling practices, methods, facilitative skills, and the application of these skills;			
Counseling Practicum (as defined in ARSD 20:68:03:02 (c))			
Counseling Internship (as defined in ARSD 20:68:03:02 (d))			
Human growth and development: including studies that provide a broad understanding of the nature and needs of individuals at all developmental levels with emphasis placed on psychological, sociological approaches and areas such as normal and abnormal human behavior, personality theory, and learning theory;			
Social and Cultural Foundations: including studies of change, ethnic groups, subcultures, changing roles of women, sexism, urban and rural societies, population patterns, cultural mores, use of leisure time, and differing life patterns;			
The helping relationship: individuals working together to resolve a conflict or difference and foster the personal growth and development of one of the two people. At least one of the parties has the intention of function and improved coping with the life of the other party;			

Content Area	Course Number(s)	Course Title(s)	College/ University
Group counseling: including theory and types of groups, as well as descriptions of group practices, methods, dynamics, facilitative skills, and supervised practice;			
Life-style and career development: including areas such as vocational-choice theory, relationship between career choice and life-style, sources of occupational and educational information, approaches to career decision-making processes and career development exploration techniques;			
Individual appraisal: including the development of a framework for understanding the individual, including methods of data-gathering and interpretation, individuals and group testing, case study approaches, the study of individual differences, and consideration of ethnic, cultural, and sex factors;			
Research and evaluation: including areas such as statistics, research design, the development of research and demonstration proposals, and the development and evaluation of program objectives;			
Professional orientation: professional, legal, and ethical responsibilities including: goals and objectives of professional counseling organizations, codes of ethics, legal considerations, standards of preparation, certification and licensing, and the role identity of counselor.			
Psychopathology: including the general principles and practices of etiology, diagnosis, treatment, and prevention of mental and emotional disorders and dysfunctional behavior, and the general principles and practices for the promotion of optimal mental health;			
Clinical assessment: including the specific models and methods for assessing mental status and the identification of mental illness or abnormal, deviant, or psychopathologic behavior by obtaining appropriate behavioral data using a variety of techniques, including non-projective personality assessments and achievements, aptitude, and intelligence testing, and translating findings in the diagnostic and statistical manual categories;			
Psychopharmacology: including the basic classification, indications, and contraindications of the commonly prescribed psychopharmacological medications for the purpose of identifying the effects and side effects of prescribed psychotropic medications;			
Case management: including the guidelines for conducting an intake interview and mental health history for planning and managing of client caseload manual categories;			
Foundation of mental health: including the specific concepts and ideas related to mental health education, outreach, prevention, and mental health promotion.			

Mail completed form with application to: SD Board of Examiners for Counselors and MFTs, PO Box 2164, Sioux Falls, SD 57101